U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 December 2003

CASE No.: 2003-BLA-05133

In the Matter of

IVAN C. KLINGER
Claimant

v.

KOCHER COAL COMPANY
Employer

LACKAWANNA CASUALTY CO.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Carolyn M. Marconis, Esq.	John J. Notarianni, Esq.	Joseph T. Crawford
For Claimant	For Employer	For Party-in-Interest

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was

[1] The regulations cited are the amended regulations, effective January 19, 2001, found at 20 C.F.R. §718, et. seq. (2001).

due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On November 5, 2002, this case was referred to the Office of Administrative Law Judges for a formal hearing. DX 35. Subsequently, the case was assigned to me. The hearing was held before me in Reading, Pennsylvania, on June 5, 2003, at which time the parties had full opportunity to present evidence and argument.[2] Claimant filed a brief on August 27, 2003. Employer filed a brief on August 21, 2003. This decision is based upon an analysis of the record, the arguments of the parties and the applicable law.

I. ISSUES

The following issues are presented for adjudication:

(1) whether Claimant has pneumoconiosis;

(2) whether Claimant's pneumoconiosis arose out of coal mine employment;

(3) whether Claimant is totally disabled;

(4) whether Claimant's total disability is due to pneumoconiosis;

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Claimant filed a claim for benefits on May 15, 2001. DX 2. On September 5, 2002 the District Director denied the miner's claim in a Proposed Decision and Order. DX 30. Subsequently, Claimant requested a formal hearing. DX 31.

B. Factual Background

Claimant was born on September 10, 1929. DX 6. He married Pauline Elizabeth Dietrich on June 17, 1950 and she is his only dependent for purposes of augmentation of benefits. (DX 7, DX 2). The parties have stipulated to 19 years of coal mine employment. Tr. 14. I find the record supports this stipulation.

Claimant provided testimony regarding his previous coal mine employment. Claimant testified that he worked for Kocher Coal Company for approximately 10 or 11 years until he ceased employment with them in 1987. Tr. 15-16 Claimant testified that when he first started working for Kocher he worked in the filtration plant. Tr. 15. At the filtration plant, Claimant took dirt from the coal and cleaned coal out of the water. Tr. 16. He dealt mainly with raw coal that as being processed. Tr. 16. Claimant stated that his job required him both to sit and stand

[2] At the hearing, Employer withdrew evidence that was in excess of the regulatory limitations on evidence.

throughout the day. TR. 17. Claimant shoveled the chute when it became blocked up and also performed maintenance duties on equipment that required him to crawl and climb. Tr. 17-19. In the course of his work, Claimant handled 50 gallon drums. Tr. 19. Claimant also testified that he occasionally picked rocks out of the coal that was being processed. TR. 20. He said that he was exposed to coal dust. Tr. 18.

Claimant described his work in the coal industry other than at Kocher as shoveling rock and pushing buggies. Tr. 21. He stated that the environment was very dusty stating "you couldn't see your hands or face and things like that." Tr. 21. After working at Kocher, Claimant testified that he worked at J.E. Morgan, loading and unloading trucks, for four years until he retired. Tr. 21.

Presently, Claimant complains of trouble breathing that is getting increasingly worse. Tr. 22. He said that his breathing difficulties prevent him from engaging in activities that he enjoys, including gardening and other outside work. Tr. 25. Claimant has difficulty walking two or three blocks and can only climb two or three stairs at a time due to breathing problems. Tr. 22. Claimant testified that he was prescribed an inhaler to assist him in his breathing, but discontinued using it after six months because it "[d]idn't seem to help." Tr. 24. Claimant admitted that he smoked for approximately 8 to 10 years, but said that he had quit smoking 33 years ago. Tr. 24. He smoked one pack every 3-5 days. Tr. 24.

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. §718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

D. Elements of Entitlement

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §718.202(a)(1) through (a)(4):

(1) X-ray evidence. §718.202(a)(1).

(2) Biopsy or autopsy evidence. §718.202(a)(2).

(3) Regulatory presumptions. §718.202(a)(3).

a) §718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) §718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) §718.306 – Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

(4) Physician's opinions based upon objective medical evidence §718.202(a)(4)

The Third Circuit has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." Penn Allegheny Coal Co. v. Williams, 114 F.3d 22, 25 (3d Cir. 1997).

X-ray evidence, §718.202(a)(1)

Under §718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with §718.102.[3] The current record contains the following chest X-ray evidence.[4]

[3] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51 A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

[4] A July 24, 2001 radiology report signed by Dr. Joe E. Conrad was also submitted in Director's Exhibit 18 among Dr. Georgetta Lupold's treating records. There is no medical opinion report or testimony that addresses this chest x-ray, and therefore, there is no means of ascertaining its validity or meaning.

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASS
1/10/01	2/23/01	DX 15	Dr. Smith	B – Reader, BCR	1/0
7/5/01	4/18/03	CX 1	Dr. Smith	B – Reader, BCR	1/0
7/5/01	7/9/01	DX 13	Dr. Rashid	None	0/0
9/7/01	9/07/01	EX 1	Dr. Ciotola	B – Reader, BCR*	0/0
9/7/01	5/27/02	EX 3	Dr. Soble	B – Reader, BCR*	0/0
9/7/01	6/19/02	DX 29	Dr. Smith	B – Reader, BCR	1/0
9/7/01	11/8/01	DX 44	Dr. Sundheim	B – Reader, BCR	Unreadable

*These doctors were found to be board certified in radiology as listed on www.abms.org ; their board certifications were not otherwise part of the record.

** Dr. Peter J. Barrett's August 15. 2001 rereading of the July 5, 2001 x-ray was for film quality only. DX 14. He determined the film quality of the x-ray to have a value of 2. DX 14

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co. 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The film taken on January 10, 2001 was interpreted as positive for the presence of pneumoconiosis. Accordingly, I find the chest x-ray to be positive for the presence of pneumoconiosis.

The film taken on July 5, 2001 was interpreted as positive by Dr. Smith. Dr. Rashid found this x-ray to be negative for the presence of pneumoconiosis. Dr. Smith is a B-reader and board certified in radiology. While the record indicates that Dr. Rashid is board certified in internal medicine, he lacks comparable radiological qualifications. Accordingly, I give more weight to Dr. Smith's interpretation and find that the chest x-ray is positive for the presence of pneumoconiosis.

The film taken on September 7, 2001 was interpreted as positive for the presence of pneumoconiosis by Dr. Smith, a B-reader and board certified in radiology. The same film was interpreted as negative by Dr. Soble and Dr. Ciotola, who are both also are B-readers and board certified in radiology. The September 7, 2001 film was considered unreadable by Dr. Sundheim, a B-reader and board certified in radiology. I find the evidence regarding the September 7, 2001

film to be in equipoise and therefore, does not support a finding of the presence of pneumoconiosis.

Considering all of the X-ray evidence together, I find that the weight of the X-ray evidence supports a finding of the presence of pneumoconiosis.

Biopsy or autopsy evidence, §718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, §718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e) Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under §718.202(a)(3).

Physicians' opinions, §718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201 (a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment

> significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The record contains the following physician's opinions.

Dr. Raymond J. Kraynak

In an April 29, 2003 medical report, Dr. Raymond Kraynak noted Claimant's complaints of exertional dyspnea, productive cough and shortness of breath, secondary to pneumoconiosis. CX 2. Dr. Kraynak noted Claimant's smoking history of 1 pack every five days, with cessation 30 years ago. CX 2. He characterizes Claimant's smoking history as "minimal" and concluded that it "would not give rise to any pulmonary disease." CX 4. The physician also noted Claimant's occupational history in the coal mine industry as "10 years above ground, 12 years underground." Dr. Kraynak has seen Claimant approximately every two months since January 10, 2001.

> Based upon Mr. Klinger's history of having worked in the anthracite coal industry in excess of ten years, the complaints with which he has presented, my physical examination and the diagnostic studies performed, it is my opinion that he is totally and permanently disabled, secondary to Coal Workers' Pneumoconiosis, contracted during his employment in the anthracite coal industry. He is unable to lift, carry, climb steps or walk for any period of time. He must be able to sit, stand and lay at his leisure, secondary to his severe respiratory impairment. CX 2.

Dr. Kraynak based his opinion on his own examination of the Claimant, a January 10, 2001 pulmonary function study and a January 10, 2001 chest x-ray interpreted by Dr. Smith as positive for pneumoconiosis. Dr. Kraynak also reviewed a medical report submitted by Dr. Dittman and blood gas and pulmonary function studies done by Dr. Rashid. CX 4. Dr. Kraynak examined Claimant and reported "mild increase in AP diameters; scattered wheezes in all lung fields; no rales or rhonci ausculated." CX 2. The physician explained variations in the pulmonary function study values as "reflective of the gentlemen's clinical ability at the time the study's given." CX 4. Dr. Kraynak stated that Claimant's lips were "cyanotic, indicative of a lowered blood oxygen level." CX 4. The physician stated that Claimant has no history of cardiac problems. CX 4.

Dr. Thomas Dittman

In a medical report dated September 11, 2001 Dr. Thomas Dittman (Board-certified in internal medicine, medical director of Pulmonary Disease Clinic at Hazelton General Hospital) opined that Claimant did not have pneumoconiosis. DX 17. Dr. Dittman noted Claimant's past medical history of vein stripping, surgery for a perforated ear drum and total knee arthroplasty. EX 5. He noted Claimant's previous employment in the coal industry. EX 5. The physician performed a medical examination of Claimant's chest and lungs on September 7, 2001 and reported that Claimant's lungs were normal to inspection, palpitation and percussion. DX 17. Dr. Dittman noted a smoking history of half a pack a day for 16 years DX 17. Dr. Dittman stated that there is no clubbing of the fingers, or edema. EX 5. The physician also reviewed the results

of an electrocardiogram, pulmonary function test, and arterial blood gas study, all of which were performed on September 7, 2001. Dr. Dittman found the results of the arterial blood gas study to be normal. Dr. Dittman determined that the effort for the pulmonary function testing was inconsistent and less than maximum. DX 17; EX 5-16. He testified that there was a "hesitant flow in the exhalation" and finds the study invalid. Id. Despite the noted inconsistent effort, the physician found that the "study does not demonstrate evidence of a restrictive defect even with reduced effort." DX 17.

Dr. Dittman reviewed Dr. Ciotola's interpretation of the September 7, 2001 chest X-ray film, which Dr. Ciotola considered to be negative for the presence of pneumoconiosis. DX 17. Dr. Dittman testified that he had reviewed the January 10, 2001 chest x-ray interpreted by Dr. Henry K. Smith, the July 5, 2001 and September 7, 2001 chest x-rays interpreted by Dr. Smith as positive for pneumoconiosis, and considered those tests when he rendered his opinion. EX 5-16. Dr. Dittman found no presence of pneumoconiosis or other respiratory impairment, but does think Claimant has angina pectoris evidenced by chest pain that occurred during exertion.

Dr. Georgetta Lupold

The record also contains treatment records of Dr. Georgetta Lupold. DX 18. On July 26, 2001 an examination of the Claimant's lungs revealed "a few rales at the base." DX 18. Subsequent treatment records deal primarily with Claimant's knee problems and ear problems. DX 18. The handwritten records submitted are largely illegibly. DX 18. A July 31, 2001 Consultation Report from Good Samaritan Regional Medical Center described Claimant's lungs as "[e]ssentially clear" with no wheezing or rhonchi. DX 18. A radiology report on a chest x-ray dated July 24, 2001 diagnosed the Claimant has having a "normal chest" and noted "no abnormalities of the heart, lungs, or mediastinum of the bony thorax." DX 18.

I find the treatment records of Dr. Lupold to be of little to no weight because there is no medical report that addresses their validity or probative value on the issue of the presence of pneumoconiosis.

I find Dr. Kraynak's opinion to be well-documented and reasoned. An opinion is well-documented and reasoned when it is based on evidence such as physical examinations, symptoms, and other adequate data that support the physician's conclusions. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). The doctor's opinion regarding the presence of pneumoconiosis was based upon medical examinations and valid chest X-ray interpretations that I have found demonstrate the presence of the disease. Although I decline to accord his opinion controlling weight[5], I give some additional weight to Dr. Kraynak's opinion because Claimant has been under his treatment since January 10, 2001.

In contrast, Dr. Dittman concludes that Claimant does not have pneumoconiosis, despite being provided evidence of such in the form of valid X-rays. In addition, Dr. Dittman concluded

[5] The record does not provide sufficient evidence regarding the extent of his treatment of Claimant to warrant the grant of controlling weight. 20 C.F.R. section 718.204(d)(1)-(5).

that Claimant's symptoms were due to angina, a condition for which Claimant is not diagnosed or treated. EX 5-16, 17. Despite his superior qualifications as a physician who is board certified in internal medicine and specializes in pulmonary disease, I accord little weight to Dr. Dittman's opinion because it is not well-documented. DX 17. A medical opinion that is undocumented or unreasoned may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989); see also Duke v. Director, OWCP, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis).

Consequently, I find that the medical opinion evidence establishes the presence of pneumoconiosis. The x-ray evidence also demonstrates the presence of the disease. Based on the forgoing, I find that Claimant has established this element of entitlement.

2. Pneumoconiosis Arising Out of Coal Mine Employment

Employer states in its brief that if Claimant established the presence of pneumoconiosis, then it concedes that the disease arose out of Claimant's coal mine employment. (Employer Brief pg. 9) A miner who is suffering or suffered from pneumoconiosis and was employed for ten years or more in one or more coal mines is entitled to a rebuttable presumption that the pneumoconiosis arose out of such employment §718.203(b). As previously stated, parties stipulate to 19 years of coal mine employment. Based on the foregoing, I find that Claimant has established this element of entitlement.

3. Total Disability

Claimant must establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner
>
> (i) From performing his or her usual coal mine work; and
> (ii) From engaging in gainful employment . . . in a mine or mines . . .

§718.204(b)(1).

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. §718.204(a); see also, Beatty v. Danri Corp., 16 B.L.R. 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993 (3d Cir. 1995).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. §718.204(b)(2)(i-iv). Producing evidence under one of these four

ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. §718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of pulmonary function study results is dependent on Claimant's height, which was noted as 70 inches, 71 inches and 69 inches in the three studies. I averaged these three heights and used a height of 70 inches in evaluating the studies. Protopappas v. Director, OWCP, 6 B.L.R. 1-221 (1983).

The current record contains the pulmonary function studies summarized below:

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1/FVC	EFFORT	QUALIFIES
1/10/01	DX 15	Dr. Kraynak	71	.53	1.99	34	27%	Good	Yes
7/5/01	DX 12	Dr. Rashid	71	3.29 3.31	4.30 4.27	94 87	77% 76%	Good Good	No No
9/7/01	DX 17	Dr. Dittman	71	2.11 1.43*	3.72 3.27*	74 53*	56% 43%*	Inconsistent	No Yes
5/12/03	CX 3	Dr. Kraynak	73	2.37*	3.90	73	61%	Good	Yes

*post-bronchodilator

Two of the four pulmonary function tests produced values that were qualifying under the regulations. Dr. Dittman invalidated the study of September 7, 2001 concluding that Claimant had put forth inconsistent effort during testing. EX 5. Dr. Dittman's opinion is uncontroverted, and entitled to weight. Moreover, the test of September 7, 2001 produced results that are both qualifying and not qualifying, and, therefore, I find this test to be of little probative value. Consequently, I find that this study does not support a finding of total disability pursuant to §718.204(b)(2)(i).

In a July 10, 2001 letter, Dr. Sander Levinson invalidated the January 10, 2001 pulmonary study on the grounds that the FVC curves indicate an "unsatisfactory start of exhalation characterized by excessive hesitation. EX 2. He also stated that not all FVC curves have been displayed because of "evidence of exhalation occurring before the zero point and therefore the results reported as the FEV1 and forced vital capacity do not represent the true and complete capacities of Mr. Klinger." EX 2. Dr. Levinson found that the MVV curves are variable and only continue for 9 ½ seconds, which is less than the 12 seconds that are required. EX 2. Dr. Kraynak contended that based on his review of the tracings "there was a crisp starting

of exhalation." CX 4. He also found that exhalation started exactly at the zero point and that the MVV curves continue for required 12 seconds, contrary to Dr. Levinson's findings. CX 4.

I accord more weight to Dr. Levinson's opinion because of his superior qualifications. Dr. Levinson is board certified in internal medicine with a subspecialty of pulmonary disease. DX 16. He is also an assistant professor at Temple University School of Medicine. DX 16. It is well established that pulmonary function tests are effort-dependant and no weight may be given to studies where Claimant puts forth a poor effort. Houchin v. Old Ben Coal Co., 6 B.L.R. 1-1141 (1984). I decline to accord additional weight to Dr. Kraynak's opinion because he was present at the test. *cf.* Revnack v. Director, OWCP, 7 B.L.R. 1-771 (1985). I find that Dr. Levinson's explanation regarding the validity of the test is better reasoned. Accordingly, I find that this study does not support a finding of total disability pursuant to §718.204(b)(2)(i).

In a May 21, 2003 letter, Dr. Sander Levinson invalidated the May 12, 2003 pulmonary study administered by Dr. Kraynak. EX 4. Dr. Levinson explained that the test showed that "exhalation has not been preceded by a maximal inspiration." Id. He noted that each of the flow volume curves "indicates a gap between inhalation and exhalation suggesting that the patient has been disconnected from the spirometer[.]" Id. He also stated that the exhalation curves suggest that the patient was intentionally coughing during the study. EX 5. Dr. Levinson noted "hesitation at the onset of exhalation" and that "MVV curves indicate a variable and inconsistent effort." EX 4. Dr. Kraynak testified that he administered the study and observed Claimant throughout and found his effort and cooperation to be good. CX 4-9. The physician also stated that the equipment was calibrated that day with a 3-liter syringe. Id. As previously stated, Dr. Levinson possesses superior credentials and I give his opinion more weight. Moreover, I find his opinion to better reasoned and conclude that the study is invalid. Consequently, this study does not support a finding of total disability pursuant to §718.204(b)(2)(i).

In consideration of all of the pulmonary function study evidence, I find that Claimant has not established total disability pursuant to §718.204(b)(2)(i).

The current record contains the arterial blood gas studies summarized below:

DATE	EX. NO.	PHYSICIAN	PCO2	PO2	QUALIFIES
7/6/01	DX 11	Dr. Rashid	36	89	No
7/24/01	DX 18	Dr. Guastavino	40	65	No
9/7/01	DX 17	Dr. Dittman	38	75	No

The blood gas studies did not yield qualifying results. Based on the foregoing, Claimant has not established total disability under the provisions of §718.204(b)(2)(ii).

Under §718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-

sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. §718.204(b)(2)(iv).

Dr. Dittman testified that the objective evidence demonstrates that Claimant is not totally disabled, even assuming that Claimant has pneumoconiosis. EX 5-20. Dr. Dittman concluded from his examination and the objective test data that Claimant does not suffer from a pulmonary or respiratory impairment. EX 5-21. Dr. Dittman cited the arterial blood gas study results and a pulmonary function study, which he concluded showed good results when good effort was expended. EX 5-20. (I have found this test to be of no probative value because it produced both qualifying and non-qualifying results).

Dr. Kraynak found Claimant to be totally and permanently disabled due to pneumoconiosis. His opinion was based on "the history given to me by Mr. Klinger, my physical examinations, and reviewing all of the evidence both positive and negative." CX-4-10. In reaching his conclusion that Claimant was totally disabled, Dr. Kraynak relied, at least in part, on the two pulmonary function studies in the record which I have found to be invalid. A medical opinion that relies on a nonconforming pulmonary function test may properly be given less weight. Arnoni v. Director, OWCP, 6 B.L.R. 1-423 (1983). Though Dr. Dittman also relied in part on invalidated pulmonary function studies, his opinion is not entitled to less weight because "had the Claimant understood or cooperated more fully, the test results could only have been higher." *See* Crapp v. U.S. Steel Corp., 6 B.L.R. 1-476 (1983). Accordingly, I find Dr. Dittman's opinion is better reasoned and entitled to more weight. Dr. Dittman's opinion is entitled to additional weight because of his superior credentials. I find that the medical opinion evidence does not establish that Claimant is totally disabled.

As previously noted, the pulmonary function tests and arterial blood gas studies do not establish total disability. The medical opinion evidence also fails to establish total disability. Based on the forgoing, Claimant has not established this element of entitlement.

4. Total Disability Due to Pneumoconiosis

Since Claimant has not proven total disability, there is no need to resolve the causation issue.

F. Conclusion

As Claimant has only established the presence of pneumoconiosis, one of the four required elements of entitlement, the claim must be denied.

ATTORNEY FEE

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of Ivan C. Klinger for benefits under the Act is DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C.